		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Hwy - Box C (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** ( )

HFS ID Number: 37-0841562008

Date of Initial License for Current Owners: 1969

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William E Castor **Telephone Number:** 217-525-111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1,2004 to June 30, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,543	2,381	2,151	11,075	8
9	SNF/PED					9
10	ICF	1,012	480		1,492	10
11	ICF/DD					11
12	SC	71	5,645		5,716	12
13	DD 16 OR LESS					13
14	TOTALS	7,626	8,506	2,151	18,283	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.79%

D. How many bed-hold days during this year were paid by the Department?
244 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 43 and days of care provided 2,151

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1,2004 **Ending:** June 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	141,408	12,159	5,437	159,004		159,004		159,004			1
2	Food Purchase		102,155		102,155		102,155	(3,138)	99,017			2
3	Housekeeping	93,364	19,937		113,301		113,301		113,301			3
4	Laundry											4
5	Heat and Other Utilities			69,445	69,445		69,445	(3,682)	65,763			5
6	Maintenance	33,437	7,735	20,302	61,474		61,474	4,446	65,920			6
7	Other (specify):*											7
8	**TOTAL General Services**	268,209	141,986	95,184	505,379		505,379	(2,374)	503,005			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	702,078	110,080	148,796	960,954		960,954	(788)	960,166			10
10a	Therapy			87,706	87,706		87,706		87,706			10a
11	Activities	25,109			25,109		25,109	388	25,497			11
12	Social Services	48,287	1,309	5,990	55,586		55,586		55,586			12
13	CNA Training											13
14	Program Transportation			60	60		60		60			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	775,474	111,389	247,352	1,134,215		1,134,215	(400)	1,133,815			16
	C. General Administration											
17	Administrative	62,525	1,206	153,300	217,031		217,031	(123,960)	93,071			17
18	Directors Fees											18
19	Professional Services			43,387	43,387		43,387	5,008	48,395			19
20	Dues, Fees, Subscriptions & Promotions			46,687	46,687		46,687	(27,454)	19,233			20
21	Clerical & General Office Expenses	41,617	2,792	44,247	88,656		88,656	35,159	123,815			21
22	Employee Benefits & Payroll Taxes			240,188	240,188		240,188	14,238	254,426			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,655	18,655		18,655	2,000	20,655			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,179	68,179		68,179	434	68,613			26
27	Other (specify):*											27
28	**TOTAL General Administration**	104,142	3,998	614,643	722,783		722,783	(94,575)	628,208			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,147,825	257,373	957,179	2,362,377		2,362,377	(97,349)	2,265,028			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beulah Land Christian Home #0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			111,641	111,641		111,641	8,851	120,492			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,711	28,711		28,711	(2,495)	26,216			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,352	140,352		140,352	6,356	146,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,868	6,868		6,868		6,868			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			30,411	30,411		30,411		30,411			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,147,825	257,373	1,127,942	2,533,140		2,533,140	(90,993)	2,442,147			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,552)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,803)	5		5
6	Rented Facility Space	(3,100)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(23,467)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,684)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	9,518	21		24
25	Fund Raising, Advertising and Promotional	(940)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(7,807)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,835)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,158)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (45,158)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (90,993)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Beulah Land Christian Home

ID# **0006767**

Report Period Beginning: **July 1,2004**

Ending: **June 30, 2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 414	2	1
2	Activity	388	11	2
3	Miscellaneous	(100)	21	3
4	Exempt Interest Income - Endowment	20,800	32	4
5	Loss on Disposal	(1,081)	21	5
6	Marketing Expense	(26,514)	20	6
7	Related Pharmacy Profit	(788)	10	7
8	Marketing Travel	(926)	24	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,807)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,138)	0	0	0	0	0	0	0	0	0	0	(3,138)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,903)	5,221	0	0	0	0	0	0	0	0	0	(3,682)	5
6	Maintenance	0	4,446	0	0	0	0	0	0	0	0	0	4,446	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,041)	9,667	0	0	0	0	0	0	0	0	0	(2,374)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(788)	0	0	0	0	0	0	0	0	0	0	(788)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	388	0	0	0	0	0	0	0	0	0	0	388	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(400)	0	0	0	0	0	0	0	0	0	0	(400)	16
	C. General Administration													
17	Administrative	0	(123,960)	0	0	0	0	0	0	0	0	0	(123,960)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,008	0	0	0	0	0	0	0	0	0	5,008	19
20	Fees, Subscriptions & Promotions	(27,454)	0	0	0	0	0	0	0	0	0	0	(27,454)	20
21	Clerical & General Office Expenses	(2,347)	37,506	0	0	0	0	0	0	0	0	0	35,159	21
22	Employee Benefits & Payroll Taxes	0	14,238	0	0	0	0	0	0	0	0	0	14,238	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(926)	2,926	0	0	0	0	0	0	0	0	0	2,000	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	434	0	0	0	0	0	0	0	0	0	434	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(30,727)	(63,848)	0	0	0	0	0	0	0	0	0	(94,575)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,168)	(54,181)	0	0	0	0	0	0	0	0	0	(97,349)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Beulah Land Christian Home** **#** **0006767** **Report Period Beginning:** **July 1,2004** **Ending:** **June 30, 2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	8,851	0	0	0	0	0	0	0	0	0	8,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,667)	172	0	0	0	0	0	0	0	0	0	(2,495)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,667)	9,023	0	0	0	0	0	0	0	0	0	6,356	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,835)	(45,158)	0	0	0	0	0	0	0	0	0	(90,993)	45

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		5	Utilities	$	Christian Homes Inc	100.00%	$ 5,221	$ 5,221	1
2	V		6	Maintenance				4,446	4,446	2
3	V		17	Administrative	153,300			29,340	(123,960)	3
4	V		19	Professional Services				5,008	5,008	4
5	V		21	Clerical				37,506	37,506	5
6	V		22	Employee Benefits				14,238	14,238	6
7	V		24	Travel & Seminar				2,926	2,926	7
8	V		26	Insurance				434	434	8
9	V		30	Depreciation				8,851	8,851	9
10	V		32	Interest				172	172	10
11	V									11
12	V									12
13	V									13
14	Total				$ 153,300			$ 108,142	$ * (45,158)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: ne 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996-A GR Bonds	x		Operations		07/01/96	$ 225,000	$ 189,000	07/01/21	0.0700	$ 13,376	1
2	1998-C GR Bonds	x		Operations		11/01/98	480,060		01/05/05	0.0700	836	2
3	2001-X GR Bonds	x		Operations		10/01/01	200,000	198,133	10/01/31	0.0650	13,935	3
4	Bond Financing Fee										564	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 905,060	$ 387,133			$ 28,711	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 905,060	$ 387,133			$ 28,711	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1,2004 **Ending:** June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ n/a	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beulah Land Christian Home COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0006767

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-13-27-226-004	S27 T28 R3	$ 85.82	$
2.	13-13-27-203-001	S27 T28 R3	$ 255.94	$
3.	13-13-27-201-012	S27 T28 R3	$ 971.38	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,313.14	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,000	Various	$ 19,470	1
2	Home Office			3,802	2
3	TOTALS	16,000		$ 23,272	3

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1982	1982	$ 1,279,926	$ 31,998	40	$ 31,998	$	$ 737,287	4
5	32		1974	1974	417,998	8,360	50	8,360		289,697	5
6											6
7											7
8	Home Office Allocation				27,521	887		887		13,826	8
	Improvement Type**										
9	Land Improvement			1977	7,756	155	50	155		4,419	9
10	Insulated Windows			1979	16,273	370	44	370		9,497	10
11	Ceiling Replaced			1981	1,118	26	43	26		650	11
12	Heating & A/C			1982	25,614		20			25,614	12
13	Bldg Improvement			1982	28,428	711	40	711		16,383	13
14	Bldg Improvement			1982	7,375	184	40	184		4,202	14
15	Bldg Improvement			1982	36,352	909	40	909		20,525	15
16	Insulation			1983	4,400	147	30	147		3,307	16
17	Improvements			1983	2,925	98	30	98		2,173	17
18	Hot Water System			1985	1,577	43	20	43		1,577	18
19	Edge Protectors, Etc			1985	507		15			507	19
20	Light Fixtures			1985	406		15			406	20
21	Garage Work			1985	23,170		15			23,170	21
22	Ceiling Tiles			1985	225		15			225	22
23	Bldg Improvement			1986	36,762	919	40	919		17,921	23
24	Light Fixtures - 1/2			1987	610		10			610	24
25	Window 1/2			1987	840	42	20	42		763	25
26	Hot Water System 1/2			1988	979	49	20	49		849	26
27	Chg Water Piping 1/2			1988	390	20	20	20		347	27
28	Water Heater Consult			1988	961		15			961	28
29	Door Alarm System			1988	1,900	95	20	95		1,599	29
30	Vinyl Siding			1988	3,410	171	20	171		2,864	30
31	Blank										31
32	Door Monitor Panel			1989	1,980		10			1,980	32
33	Compressors (2)			1989	924		10			924	33
34	Compressors			9/12/1989	2,306		10			2,306	34
35	Compressor (1)			1989	693		10			693	35
36	Emerg Power Kitchen Light			1990	329		5			329	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Lavatories/Faucets	1990	$ 1,679	$	5	$	$	$ 1,679	37
38	Carpeting	1990	300		5			300	38
39	Compressor	1991	1,828		10			1,828	39
40	Blank								40
41	Insulating Glass	1991	2,256	68	33	68		929	41
42	Door Monitor	1992	1,440		10			1,440	42
43	Room Windows (3)	1992	2,696	135	20	135		1,721	43
44	A/C Units (5)	1992	5,859		8			5,859	44
45	Sinks/Faucets	1993	537		5			537	45
46	Door Monitor	1993	1,700		10			1,700	46
47	Mix Valve/Faucet	1993	2,953		10			2,953	47
48	Auto Sprinkler	1993	580		10			580	48
49	Door Access System	1993	602		10			602	49
50	Wallcoverings	1993	5,315		5			5,315	50
51	Carpet/Wallpaper	1993	9,540		5			9,540	51
52	Drapes	1994	4,878		10			4,878	52
53	Roofing Project Shelter	1994	62,189	4,146	15	4,146		45,606	53
54	Install Carrier Furnace	1994	1,877	13	10	13		1,877	54
55	Blank								55
56	Nurse Call System	1995	1,040	69	15	69		713	56
57	Upstairs Lib/Comp Room	1995	1,743	117	10	117		1,743	57
58	Garage Doors	1995	676		5			676	58
59	Wanderguard	1995	4,094	379	10	379		4,094	59
60	A/C Heating Units	1995	2,326		8			2,326	60
61	Heating/AC Units	1995	4,652		8			4,652	61
62	Carrier Central A/C	1995	2,748	275	10	275		2,681	62
63	Heating/AC Units	1995	2,326		8			2,326	63
64	Water Heater	1996	6,263	626	10	626		5,895	64
65	200 Gallon Storage Tank	1996	4,115	412	10	412		3,845	65
66	Remodel Nursing Wing	1996	3,249		5			3,249	66
67	Heating/AC Units	1996	5,235	221	8	221		5,235	67
68	Mixer/Amp	1997	975	98	10	98		800	68
69	Water Heater	1997	13,453	1,345	10	1,345		10,872	69
70	TOTAL (lines 4 thru 69)		$ 2,092,779	$ 53,088		$ 53,088	$	$ 1,322,062	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,092,779	$ 53,088		$ 53,088	$	$ 1,322,062	1
2	Eyewash Station	1997	555		5			555	2
3	Exit Lights	1997	1,102	110	10	110		862	3
4	Blank								4
5	York C/A Unit	1997	7,839	784	10	784		6,076	5
6	Floor Covering	1997	1,856		5			1,856	6
7	Wall Covering Sit & Bath	1998	2,574		5			2,574	7
8	Floor Covering - Sit & Bath	1998	1,145		5			1,145	8
9	Carpeting	1998	8,739		5			8,739	9
10	Wallpaper	1998	7,497		5			7,497	10
11	Room Signs	1998	2,270		5			2,270	11
12	Paint/Wallpaper/Carpet	1999	17,404	1,740	10	1,740		11,310	12
13	Remodel Nurses Station	1999	2,700	180	15	180		1,110	13
14	Floor Tile/Cove Base	2000	1,144	37	5	37		1,144	14
15	Carpet/Cove Base 2 Rooms	2000	576	30	5	30		576	15
16	A/C Grill Covers (13)	2000	546	37	5	37		546	16
17	Shelter Care Hallway CA	2000	3,686	247	5	247		3,686	17
18	Floor Covering	2000	1,040	87	5	87		1,040	18
19	Fire Alarm System	2000	32,965	3,297	10	3,297		17,859	19
20	Floor Tile/Cove Base	2000	1,755	205	5	205		1,755	20
21	Remodel - Chapel/Act/Bs/Dr	2000	10,705	1,071	10	1,071		5,534	21
22	AC HEATING UNIT INSTALLED	2000	505	34	15	34		159	22
23	FLOOR COVERINGS	2000	1,143	229	5	229		1,050	23
24	ENTRY SYSTEM KEYPAD/ALZ. WING	2001	775	155	5	155		633	24
25	DOOR ALARM SYSTEM	2001	1,155	116	10	116		474	25
26	Mixing Valve Installation	2001	1,649	165	10	165		660	26
27	Canopy over patio area	2001	6,612	661	10	661		2,479	27
28	Steel Door/East Side of Kitchen	2001	1,393	139	10	139		498	28
29	Floor Coverings - Rooms 404 & 417	9/27/2002	886	177	5	177		502	29
30	(2) Thru Wall Unit A/C	10/18/2002	1,348	169	8	169		465	30
31	Carrier thru-wall HTG/AC unit	3/27/2003	625	42	15	42		98	31
32	80' Red Oak Handrail & Installation	4/21/2003	2,160	144	15	144		324	32
33	Apartment Conversion	2/1/2003	31,913	2,128	15	2,128		5,143	33
34	TOTAL (lines 1 thru 33)		$ 2,249,041	$ 65,072		$ 65,072	$	$ 1,410,681	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,249,041	$ 65,072		$ 65,072	$	$ 1,410,681	1
2	Railing - Asst Living Loft Area	4/25/2003	3,456	346	10	346		779	2
3	Wiring run for Steamer & Steam Table	4/4/2003	1,644	82	20	82		185	3
4	Tile Bathrooms - Rooms 414/417/423-Carpet 423	5/30/2003	817	163	5	163		353	4
5	Compressor for Laundry A/C	7/21/2003	767	256	3	256		512	5
6	Roof Replacement	9/3/2003	31,762	2,117	15	2,117		3,705	6
7	Add Sprinkler in Mechanical Room	9/26/2003	535	107	5	107		196	7
8	High Efficiency Ballasts/Lights	11/11/2003	12,351	1,235	10	1,235		2,058	8
9	Explosion Proof Light in O2 Room	12/9/2003	1,250	250	5	250		396	9
10	Upgrade Energy Management System	3/2/2004	6,000	429	14	429		572	10
11	Addition to Fire Ext System	4/8/2004	1,338	134	10	134		168	11
12	Install Fire Wall in A/L Dining Room	5/20/2004	2,855	571	5	571		666	12
13	Fully depreciated land improvements	6/30/1974	83,212		20			83,212	13
14	Water & sewer line	11/30/1980	12,325	411	30	411		9,879	14
15	Parking lot lighting	10/31/1983	3,642		20			3,642	15
16	Sidewalk	11/30/1987	10,600	424	25	424		7,491	16
17	New sidewalk & move fire hydrant	12/12/1989	1,725	61	20	61		1,471	17
18	Outside lights	1/5/1994	2,099		10			2,099	18
19	Landscaping	6/30/1995	8,515	699	10	699		8,515	19
20	Concrete pad	6/5/1998	3,571	357	10	357		2,529	20
21	Landscaping	8/13/1998	578		5			578	21
22	Patio	11/17/2000	4,090	409	10	409		1,909	22
23	Landscaping	6/30/2001	1,975	395	5	395		1,613	23
24	Landscaping and fence	10/25/2001	16,799	1,680	10	1,680		6,468	24
25	Repair & Seal Parking Lot	7/25/2003	3,097	1,032	3	1,032		2,064	25
26	Carpet/Vinyl (Res Rm on SC side)	7/2/2004	705	141	5	141		141	26
27	5T Carrier Central AC Unit	8/20/2004	2,001	183	10	183		183	27
28	Carpet/Vinyl Cover Base Rm 415 A/L	12/31/2004	890	104	5	104		104	28
29	Gas log fireplace w/screens	1/4/2005	909	91	5	91		91	29
30	(2) Base Cabinets w/Formica top	3/30/2005	574	19	10	19		19	30
31	(6) Heat/AC Units & Installation	5/13/2005	4,105	86	8	86		86	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,473,228	$ 76,854		$ 76,854	$	$ 1,552,365	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 278,446	$ 32,869	$ 32,869	$	Various	$ 171,247	71
72	Current Year Purchases	30,565	2,805	2,805		Various		72
73	Fully Depreciated Assets	218,734				Various	218,734	73
74	Home Office Allocation	48,711	6,727	6,727			25,951	74
75	TOTALS	$ 576,456	$ 42,401	$ 42,401	$		$ 415,932	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Ford Van	2000	$ 47,500	$	$	$	4	$ 47,500	76
77										77
78										78
79	Home Office Allocation			5,719	1,237	1,237			2,176	79
80	TOTALS			$ 53,219	$ 1,237	$ 1,237	$		$ 49,676	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,126,175	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,492	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,492	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,017,973	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 202,868	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 202,868	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	appliable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1,2004 **Ending:** June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 138,607	$	1
2	Cash-Patient Deposits	4,375		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	128,730		3
4	Supply Inventory (priced at)	15,081		4
5	Short-Term Investments	29,562		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,475		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,431		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 328,261	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	222,338		13
14	Buildings, at Historical Cost	2,293,481		14
15	Leasehold Improvements, at Historical Cost	152,226		15
16	Equipment, at Historical Cost	575,247		16
17	Accumulated Depreciation (book methods)	(1,976,019)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	542,178		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	6,925		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,816,376	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,144,637	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,744	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,375		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,271		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,254		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 194,644	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	387,133		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 387,133	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 581,777	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,562,860	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,144,637	$	48

***(See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,817,436	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,817,436	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,576)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (204,576)	17
	B. Transfers (Itemize):		
18	**Transfer out to affiliate**	(50,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (50,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,562,860	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,655,483	1
2	Discounts and Allowances for all Levels	(605,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,049,843	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	143,702	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 143,702	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,000	13
14	Non-Patient Meals	3,552	14
15	Telephone, Television and Radio	5,803	15
16	Rental of Facility Space	3,100	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,054	19
20	Radiology and X-Ray	989	20
21	Other Medical Services	19,490	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 43,988	23
	D. Non-Operating Revenue		
24	Contributions	57,402	24
25	Interest and Other Investment Income***	23,467	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80,869	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Sale of Equity	10,162	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,162	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,328,564	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	505,379	31
32	Health Care	1,134,215	32
33	General Administration	722,783	33
	B. Capital Expense		
34	Ownership	140,352	34
	C. Ancillary Expense		
35	Special Cost Centers	6,868	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,533,140	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,576)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (204,576)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,790	1,801	$ 48,827	$ 27.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,894	3,920	92,303	23.55	3
4	Licensed Practical Nurses	6,614	6,625	146,753	22.15	4
5	CNAs & Orderlies	34,470	34,675	412,478	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	169	171	1,717	10.04	8
9	Activity Director	1,648	1,648	19,274	11.70	9
10	Activity Assistants	677	677	5,835	8.62	10
11	Social Service Workers	3,233	3,233	48,287	14.94	11
12	Dietician					12
13	Food Service Supervisor	1,872	1,989	26,947	13.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,960	12,460	114,461	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,879	1,891	33,437	17.68	17
18	Housekeepers	10,497	10,709	93,364	8.72	18
19	Laundry					19
20	Administrator	1,273	1,275	62,525	49.04	20
21	Assistant Administrator	92	94	670	7.13	21
22	Other Administrative					22
23	Office Manager	1,973	1,975	25,986	13.16	23
24	Clerical	495	497	14,961	30.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	82,536	83,640	$ 1,147,825 *	$ 13.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	119	$ 5,437	1.3	35
36	Medical Director	36	4,800	9.3	36
37	Medical Records Consultant	20	1,267	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	78	947	10.3	39
40	Physical Therapy Consultant	756	53,436	10A.3	40
41	Occupational Therapy Consultant	371	26,139	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	120	8,132	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	68	5,630	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,568	$ 105,788		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
W Jean Greenley	Administrator	0	$ 62,525
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,525

B. Administrative - Other

Description	Amount
Management Expense	$ 153,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 153,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 2,834
1st Farm Credit Service	Appraisal	700
American Recruiters	Employment	34,663
Krause Surveying Inc	Professional	1,860
Scott Communications	Consulting	345
RCLS	Feasibility Study	2,985
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 43,387

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,267
Unemployment Compensation Insurance	
FICA Taxes	80,733
Employee Health Insurance	101,240
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	11,656
Employee Physicals	3,700
Employee Uniforms	592
Home Office Allocation	14,238
TOTAL (agree to Schedule V, line 22, col.8)	$ 254,426

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,190
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses	805
Dues	5,706
Subscriptions	62
Miscellaneous	470
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,233

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,543
Seminar Expense	3,186
Home Office Allocation	2,926
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,655

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1,2004 Ending: June 30, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1,2004 **Ending:** June 30, 20(

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $1,522**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **0**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,225** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **23,543**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,552**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Beulah Land Christian Home
Allocation on Benefits 6/30/2005 sms
3/20/2006

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Worker's Com Med Exp.	Employee Uniforms	Employee Expense	Employee Physicals	
4,276.74		42,267.47			592.30	11,655.74		
897.77			7,760.00				3,699.50	
2,094.21			4,920.00					
9,421.96			8,640.00					
7,465.72			9,420.00					
51,380.62			61,100.00					
5,196.03			9,400.00					
80,733.05	0.00	42,267.47	101,240.00	0.00	592.30	11,655.74	3,699.50	240,188.06

Line 3.22.3 240,188.06

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